STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 7, 2011
[redacted]
AGENCY: New York City
FH #: 5944023P

In the Matter of the Appeal of

[redacted]

from a determination by the New York City Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on December 9, 2011, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For Comprehensive Care Management, the Long Term Managed Care Provider
Patricia Hanniford, Clinical Director, Fair Hearing Representative;
Claville Thomas-Taylor, Nursing Care Manager, Fair Hearing Representative

ISSUE

Has the Agency acted correctly with respect to its October 18, 2011 determination to reduce the Appellant's Personal Care Services Authorization?

Was the Long Term Managed Care Provider's November 29, 2011 determination to charge the Appellant for documents requested in order to prepare for the Fair Hearing Correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 87 is in receipt of Medical Assistance benefits. He is enrolled in a Medicaid Managed Care plan operated by Comprehensive Care Management (the Provider).

2. The Appellant was receiving a shared authorization with his wife, for a total 24 hours per day provided continuously by more than one home attendant.

3. The Appellant's wife was hospitalized. At that time, the Appellant's Personal Care Services Authorization was increased to 24 hours per day provided by more than one home attendant, rather than as a shared authorization.

4. The Appellant's wife subsequently died.

5. By a pair of notices dated October 18, 2011, the Provider advised the Appellant that his Personal Care Services Authorization would be reduced to 24 hour sleep-in service. One Notice stated an effective date of October 25, 2011; the second Notice stated an effective date of November 1, 2011.

6. The Provider's notice does not state the reason for the Agency's action, the specific laws and/or regulations upon which the action is based; and the procedures and deadlines for requesting a hearing; and the right to aid continuing.

7. On November 3, 2011, the Agency sent a Notice of Intent to the Appellant setting forth its intention to reduce the Appellant's Personal Care Services Authorization with no reason given.

8. On November 7, 2011, the Appellant requested this fair hearing.

9. The Appellant's daughter requested that the Provider provide copies of documents the Agency intended to provide at the Fair Hearing.

10. By notice dated November 29, 2011, the Provider sent the Appellant's daughter a bill for such documents, in the amount of $168.53.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. The Agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were

not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b). Except as otherwise established in law or regulation, in fair hearings concerning the discontinuance, reduction or suspension of Public Assistance, Medical Assistance, Food Stamp benefits or Services, the Agency must establish that its actions were correct. 18 NYCRR 358-5.9(a).

Regulations at 18 NYCRR 358-3.7 discusses the rights of Appellants and their representatives to request documents from the Agency in order to prepare for a Fair Hearing. The Appellant has the right to be provided at a reasonable time before the date of the hearing, at no charge, with copies of all documents which the social services agency will present at the fair hearing in support of its determination. 18 NYCRR 358-3.7(b)(1). The Appellant also has the right to be provided at a reasonable time before the date of the hearing, at no charge, with copies of any additional documents which the Appellant identifies and request for purposes of preparing for a fair hearing. 18 NYCRR 358-3.7(b)(2).

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his or her own home..."

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the managed care program for both Medicaid and Family Health Plus.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to the provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

Action means-- In the case of an MCO or PIHP—

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

Section 438.402 of 42 CFR Subpart F provides in part:

(a) The grievance system. Each MCO [Managed Care Organization] and PIHP [Prepaid Inpatient Health Plan] must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system...

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Article V.A. of the Managed Long Term Care Contract provides in part:

OBLIGATIONS OF THE CONTRACTOR

A. Provision of Benefits

1. The Contractor agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42CFR 438.210; comply with professionally recognized standards of health care and implement practice guidelines consistent with 42CFR 438.236; and comply with the requirements of 438.114 regarding emergency and post-stabilization services to the extent that services required to treat an emergency medical condition are within the scope of covered services in Appendix G.

2. Benefit package services provided by the Contractor under this Contract shall comply with all standards of the State Medicaid Plan established pursuant to State Social Services Law

Section 363-a and shall satisfy all applicable requirements of the State Public Health and Social Services Law. Non-covered services for which the Enrollee is eligible under the Medicaid Program will be paid by the Department on a fee-for-service basis directly to the provider of service.

3. The Contractor agrees to allow each Enrollee the choice of Participating Provider of covered service to the extent possible and appropriate.

4. The Contractor agrees to maintain and demonstrate to the Department's satisfaction, a sufficient and adequate network for the delivery of all covered services either directly or through subcontracts. The Contractor shall meet the standards required by 42CFR 438.206 for availability of services; and 42CFR 438.207 for assurances of adequate capacity; and applicable sections of Public Health Law and regulations. If the network is unable to provide necessary services under this Contract for a particular Enrollee, the Contractor agrees to adequately and timely furnish these services outside of the Contractor's network for as long as the Contractor is unable to provide them within the network.

Appendix K of the Managed Long Term Care Contract provides, in part:

1. GRIEVANCE SYSTEM REQUIREMENTS

The Grievance System regulations in Subpart F of 42 CFR Part 438 apply to both "expressions of dissatisfaction" by enrollees (grievances) and to requests for a review of an "action" (as defined in 438.400) by a managed long-term care plan (an appeal). For managed long-term care plans, the Grievance System processes identified in Subpart F have been combined with the grievance requirements in New York State Public Health Law (PHL) 4408-a and the utilization review and appeal requirements in Article 49 of the PHL.

A. Grievances

Grievance – An expression of dissatisfaction by the member or provider on member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

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Grievance Appeal – Expedited and Standard

1. Plan must send written acknowledgement of grievance appeal within 15 business days of receipt of request. If a decision is reached before the written acknowledgement is sent, the plan may include the written acknowledgement with notice of decision (one notice).

2. Must be decided as fast as member's condition requires, but no more than:

a. Expedited: 2 business days of receipt of all necessary information.

b. Standard: 30 business days receipt of necessary information.

3. Plan must provide written notice of decision. Notice must include reason for determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

4. No further appeal.

Appendix J of the Managed Long Term Care Contract is titled "Definitions" and provides, part:

Action is a denial or a limited authorization of a requested service or a reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to make a grievance or grievance appeal determination within required timeframes.

Appeal - a request for a review of an action taken by the Contractor.

Section B of Appendix K of the Managed Long Term Care Contract, provides in part:

B. APPEALS

An Appeal is a request for a review of an action taken by a plan.

Expedited Appeal – the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function or the action was the result of a concurrent review of a service authorization request. A member may also request an expedited review of an appeal. If an expedited review is not requested, the appeal will be treated as a standard appeal.

Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making to review the appeal, and if the appeal pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals. The plan may deny a request for an expedited review, but it must make reasonable efforts to give oral notice of denial of an expedited review and send written notice within 2 calendar days of oral request. The appeal is then handled as a standard appeal. A member's disagreement with plan's decision to handle as a standard appeal is considered a grievance – see Grievance Procedures.

An appeal may be filed orally or in writing. If oral, the plan must provide the member with a summary of the appeal in writing as part of acknowledgement or separately. The date of the oral request for both standard and expedited appeals is treated as the date of the appeal. Note: New York has elected to require that a member exhaust the plan's internal appeal process before an enrollee may request a State Fair Hearing.

Section 2 of Appendix K of the Managed Long Term Care Contract sets forth language relating to the managed long-term care demonstration grievance and appeal process which must appear in the Contractor's Member Handbook. This language includes:

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. An adequate, though not timely, notice is required where the Agency has accepted or denied an application for Public Assistance, Medical Assistance or Services; or has increased the Public Assistance grant; or has determined to change the amount of one of the items used in the calculation of a Public Assistance grant or Medical Assistance spenddown; or has determined that an individual is not eligible for an exemption from work requirements. 18 NYCRR 358-3.3(a). In addition, pursuant to 18 NYCRR 358-3.3(d), an adequate, though not timely, notice is required for a Public Assistance or Medical Assistance recipient when, for example, the Agency has factual information confirming the death of the recipient; the Agency has received a clear written statement from the recipient that he or she no longer wishes to receive Public Assistance or Medical Assistance; the Agency has reliable information that the recipient has been admitted to an institution or prison; the recipient's whereabouts are unknown and mail has been returned to the Agency; or the recipient has been accepted for Public Assistance or Medical Assistance in another district.

A timely notice means a notice which is mailed at least 10 days before the date upon which the proposed action is to become effective. 18 NYCRR 358-2.23.

An adequate notice is a notice of action, an adverse action notice or an action taken notice which sets forth the action that the Agency proposes to take or is taking, and if a single notice is used for all affected assistance, benefits or services, the effect of such action, if any, on a recipient's other assistance, benefits or services. In addition, the notice must contain:

- for reductions, the previous and new amounts of assistance or benefits provided;
- the effective date of the action;
- the specific reasons for the action;
- the specific laws and/or regulations upon which the action is based;
- the recipient's right to request an agency conference and fair hearing;
- the procedure for requesting an agency conference or fair hearing, including an address and telephone number where a request for a fair hearing may be made and the time limits within which the request for a fair hearing must be made;
- an explanation that a request for a conference is not a request for a fair hearing and that a separate request for a fair hearing must be made;
- a statement that a request for a conference does not entitle one to aid continuing and that a right to aid continuing only arises pursuant to a request for a fair hearing;
- the circumstances under which public assistance, medical assistance, food stamp benefits or services will be continued or reinstated until the fair hearing decision is issued;
- a statement that a fair hearing must be requested separately from a conference;
- a statement that when only an agency conference is requested and there is no specific request for a fair hearing, there is no right to continued public assistance, medical assistance, food stamp benefits or services;
- a statement that participation in an agency conference does not affect the right to request a fair hearing;
- the right of the recipient to review the case record and to obtain copies of documents which the agency will present into evidence at the hearing and other documents necessary for the recipient to prepare for the fair hearing at no cost;

- an address and telephone number where the recipient can obtain additional information about the recipient's case, how to request a fair hearing, access to the case file, and/or obtaining copies of documents;

- the right to representation by legal counsel, a relative, friend or other person or to represent oneself, and the right to bring witnesses to the fair hearing and to question witnesses at the hearing;

- the right to present written and oral evidence at the hearing;

- the liability, if any, to repay continued or reinstated assistance and benefits, if the recipient loses the fair hearing;

- information concerning the availability of community legal services to assist a recipient at the conference and fair hearing; and

- a copy of the budget or the basis for the computation, in instances where the social services agency's determination is based upon a budget computation.

18 NYCRR 358-2.2

In Mayer et al. v. Wing et al. (S.D.N.Y.), Plaintiffs challenged New York City's efforts to reduce their personal care services. The Court found that prior to issuing any reduction notice, the Agency must first identify some development that justifies altering a recipient's level of services. Specifically, the Agency was enjoined from reducing recipient's home care services unless the Agency's notice states that a reduction is justified because of any of a series of listed reasons. Effective October 31, 2001, relevant sections of 18 NYCRR 505.14(b) were amended to include the following requirements, consistent with the Mayer decision, for Agency determinations and notices of determination to reduce, discontinue, or deny Personal Care Services, as to reasons for the Agency to select from when issuing relevant notices. The Regulations mention the following approved reasons for taking such action, to be written on the notice:

(1) the client’s medical, mental, economic or social circumstances have changed and the district determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;

(2) a mistake occurred in the previous personal care services authorization;

(3) the client refused to cooperate with the required assessment of services;

(4) a technological development renders certain services unnecessary or less time consuming;

(5) the client can be more appropriately and cost-effectively served through other Medicaid programs and services;

(6) the client's health and safety cannot be assured with the provision of personal care services;

(7) the client's medical condition is not stable;

(8) the client is not self-directing and has no one to assume those responsibilities;

(9) the services the client needs exceed the personal care aides scope of practice; and

(10) the client resides in a facility or participates in another program or receives other services which are responsible for the provision of needed personal care services.

DISCUSSION

The evidence establishes that the Appellant, age 87, is in receipt of Medical Assistance benefits. The Appellant is enrolled in a Medicaid Managed Care plan operated by Comprehensive Care Management (the Provider).

The Appellant was receiving a shared authorization with his wife. Each was authorized to receive 12 hours per day of Personal Care Services, for a total 24 hours per day provided continuously by more than one home attendant. The Appellant's wife was hospitalized in or about October 2011. At that time, the Appellant's Personal Care Services Authorization was increased to 24 hours per day provided by more than one home attendant. The Appellant's wife subsequently died.

By a pair of notices dated October 18, 2011, the Provider advised the Appellant that his Personal Care Services Authorization would be reduced to 24 hour sleep-in service. One Notice contained an effective date of October 25, 2011; the second contained an effective date of November 1, 2011. For the purposes of this hearing they are treated as one determination.

The Provider argues that this was not a reduction in the Authorization. This argument is without merit. It is uncontroverted that, upon his wife's hospitalization, the Appellant's Personal

Care Services were increased to 24 hour continuous care because his wife's portion of the care had been either discontinued or suspended upon her hospitalization. It is clear that 24 hour sleep-in service is a lower amount of authorized care than is 24 hour continuous care. Furthermore, the Provider's notice states that this is a reduction in the authorization.

For the following reasons, the Agency's determination cannot be sustained.

Medicaid Managed Care providers agree, as part of their contract with the Department of Health, to comply with all requirements of New York State Social Services Law. This includes all relevant statutes, regulations, and policy directives.

At a Fair Hearing, the Provider is required to provide the complete relevant case record. The Agency was duly notified of the time and place of the hearing. The Provider appeared at the hearing with several documents at the hearing. However, the Agency failed to present a copy of either version of the October 18, 2011 Notice at the hearing.

With respect to the Agency's determination to reduce the Appellant's Personal Care Services Authorization without any reason given, the Agency failed to meet its obligations under 18 NYCRR 358-4.3(b) and failed to establish that its determination was correct pursuant to 18 NYCRR 358-5.9(a).

Second, a recipient of Medicaid is entitled to timely and adequate notice of an intended action. The Provider's notice must comply with the general requirements set forth in Part 358 of the Regulations, as well as the specific requirements pursuant to Mayer v. Wing regarding the reasons which must be used for discontinuing or reducing Personal Care Services Authorizations.

The Appellants' Representatives provided copies of the determination sent to the Appellant. The Provider's Notice has numerous defects under the Regulations. For example, the Provider's Notice fails to state a reason for its intended action. It fails to cite a law or regulation as the legal authority for its intended action. The Notice also fails to include information concerning how to request a Fair Hearing, the Statute of Limitations for requesting a hearing, and the right to aid continuing. These defects collectively render the Notice void.

Third, the evidence establishes that the procedures used by the Provider were improper. Social Services districts are prohibited under Mayer v. Wing from using a task based assessment to reduce a personal care services authorization where the recipient is authorized to receive continuous 24 hour care (split shift) or the equivalent when provided by a combination of formal and informal supports and caregivers. GIS 01 MA—44.

In this case, the Provider used a task based assessment to evaluate the Appellant's need for Personal Care Services. This violates Mayer v. Wing and State policy.

Therefore, the Provider's determination cannot be sustained. The Provider must restore the Appellant's Personal Care Services Authorization to 24 hour continuous care by more than one home attendant.

The Appellant's Representatives presented evidence that, prior to the Fair Hearing, they had requested that the Provider send them copies of the evidence that they intended to present at the hearing. The Provider complied with the request, but also sent a bill, dated November 29, 2011, to the Appellant, in the amount of $168.53, for the copies.

The Regulations explicitly state that upon request, the Appellant and/or the Appellant's Representative have the right to receive, *at no charge,* copies of the documents the Agency intends to present, as well as any specifically identified documents from the case record. 18 NYCRR 358-3.7 (b)(1),(2) It is therefore improper for the Provider to have sent the Appellant a bill for copies of their evidence packet. The Provider must cancel such determination, and take no action to collect a fee from the Appellant for the copying of documents to prepare for the hearing.

DECISION AND ORDER

The determination of the Agency to reduce the Appellant's Personal Care Services Authorization without reason is not correct and is reversed.

1. The Agency is directed to withdraw its Notice of Intent dated November 3, 2011, with respect to Appellant's Personal Care Services Authorization.

2. The Agency is directed to continue to provide Personal Care Services Authorization to the Appellant.

3. The Agency is directed to restore Appellant's Personal Care Services Authorization retroactive to the date of the Agency action.

The Provider's November 29, 2011 determination to charge the Appellant for documents requested in order to prepare for the Fair Hearing was not correct and is reversed.

1. The Provider is directed to withdraw its November 29, 2011 determination to recover a fee from the Appellant for copying documents requested to prepare for the Fair Hearing.

2. The Provider is directed to make no further attempt to collect a fee from the Appellant for copying documents to prepare for the Fair Hearing.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what

documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
12/21/2011

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee